



The information on this form can be submitted on the www.magellanprovider.com website. Out of network providers or providers given permission to fax can fax this form to: 888-656-2168. **Each requested service must be submitted separately. Multiple services can not be requested on the same form.**

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name		Provider First Name	
Member Last Name		Provider Last Name	
Medicaid Number		Provider MIS#	
Member Date of Birth		Provider Tax ID#	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Provider Phone	
		Provider Email	
Member Address		Provider Address	
City, State, Zip Code		City, State, Zip Code	

CLINICAL INFORMATION	
Primary Diagnosis	
Secondary Diagnosis	
Service Type	<input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use
Requested Units	
Requested Start Date	
Requested End Date	

REQUESTED SERVICE FOR REGISTRATION
<input type="checkbox"/> Mental Health Case Management
<input type="checkbox"/> Crisis Stabilization (GAP members require an authorization)
<input type="checkbox"/> Crisis Intervention
<input type="checkbox"/> Substance Use Case Management (Magellan only manages Fee For Service members)
<input type="checkbox"/> Substance Use Peer Support (Magellan only manages Fee For Service members and GAP members)
<input type="checkbox"/> Mental Health Peer Support
<input type="checkbox"/> Psychosocial Rehabilitation